HOSKINS, Angela **DOB:** 06/27/1973 (47 yo F) **Acc No.** PI19846 **DOS:** 02/04/2021

GEORGIA BRAIN & SPINE CENTER

# Hoskins, Angela

**47 Y old Female, DOB: 06/27/1973**
**Account Number: PI19846**
**175 WHEELER MARTIN DR, CANTON, GA-30115-5905**
**Home: 470-394-9570**
**Guarantor: Hoskins, Angela Insurance: Montlick & Associates**
**PCP: Jason ROBERT Hefner, MD**
**Appointment Facility: SSGEORGIA BRAIN & SPINE CENTER**

**02/04/2021** **Progress Notes: Elias Dagnew, MD**

## Current Medications

Taking
- Hydrocodone-Acetaminophen , Notes: tid
- Oxycodone HCl , Notes: 15 mg bid
- Lyrica , Notes: 75 mg bid
- Januvia , Notes: 50 mg qd
- Tizanidine HCl , Notes: 4 mg qd
- Metformin HCL 500 MG Oral Tablet , Notes: 500 mg qd

## Reason for Appointment

1. Bilateral lower extremity pain

## History of Present Illness

New/Follow-up Patient Consult:

Patient is here for follow-up evaluation. Patient reports of ongoing bilateral lower extremity radicular-type pain right greater than left. Patient describes pain extending from the right paracentral and gluteal region in a posterolateral distribution to the lateral malleolus. Patient has pain extending posteriorly along the gastrocnemius. Patient's pain occurs with standing, ambulation and range of motion activities. Patient has noted intermittent paresthesias and numbness in a similar distribution. Patient also describes left paracentral and gluteal region pain with pain extending in a posterolateral the left leg. Patient denies weakness or bowel and bladder changes. Patient requires use of analgesic medications. Patient did have temporary improvement of pain with ESI but has ongoing symptoms that affects her day-to-day activities.

## Vital Signs

Temp **97.8** F, HR **72 /min**, BP **133/75 mm Hg**, Wt **224 lbs**, BMI **39.68 Index**, Ht 63 in, Ht-cm 160.02 cm, Wt-kg 101.6 kg.

## Examination

General Examination:

GENERAL APPEARANCE: in no acute distress, well developed, well nourished.

Neurological:

CORTICAL FUNCTIONS: normal.

Neurosurgery Examination:

GENERAL APPEARANCE: normal , alert, in no acute distress, well developed, well nourished.

HEAD: atraumatic, normocephalic, no abnormalities found.

BACK: Range of motion: moderate decrease; Costovertebral angle tenderness: None, No kyphosis, No scoliosis,

Lumbarspine: positive tender to palpation,

SI Joint: non-tender to palpation

Patrick FABER: Right negative,Patrick FABER: Left negative

FAIR Test: Right negative,FAIR Test: Left negative

SLR: Right positive, SLR: Left positive.

MUSCULOSKELETAL: no joint swelling, no joint tenderness.

EXTREMITIES: good capillary refill in nail beds, no clubbing, cyanosis,

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or edema; LE no pain or edema bilateral.
PERIPHERAL PULSES: normal.
NEUROLOGIC: Alert and oriented x 3,

**CN**
CN I: Olfaction intact Left, Intact Right
CN II,III,IV, VI: PERRL, EOMI intact Left, Intact Right
CN V: V1-V3 intact Left; Intact Right
CN VII:Face Symmetric Right; Symmetric Left
CN VIII:Hearing normal Right; normal Left,
CN IX, X: Palate symmetric Right; Symmetric Left
CN XI: Shoulder shrug intact Right intact; Shoulder shrug intact Left
CN XII: Tongue midline Right; midline Left

**Motor**
Motor: **Right Arm**: 5/5 D/B/BR/T/WE/HI/Grip,
Motor: **Left Arm**: 5/5 D/B/BR/T/WE/HI/Grip,
Motor: **Right Leg**: 5/5 HF/HE/KE/KF/DF/PF/EHL,
Motor: **Left Leg**: 5/5 HF/HE/KE/KF/DF/PF/EHL

**Sensation**
Sensation: **Right Arm** LT/PP: Intact,
Sensation: **Left Arm** LT/PP: Intact,
Sensation **Right Leg**: LT/PP: patchy decrease PP,
Sensation **Left Leg**: LT/PP: Intact,

**DTR**
DTR: **Right Arm**: 2+ B;2+BR;2+T
DTR: **Left Arm**: 2+B; 2+BR; 2+T
DTR: **Right Leg**: 2+ Patella; 2+ Achilles
DTR: **Left Leg**: 2+ Patella; 2+ Achilles

Romberg: Negative,

Gait: antalgic,
Tandem Gait: decreased.

## Assessments
1. Other intervertebral disc displacement, lumbar region - M51.26 (Primary)
2. Radiculopathy, lumbar region - M54.16

## Treatment
**1. Other intervertebral disc displacement, lumbar region**
Notes: Patient is a 47-year-old lady who is here for follow-up with continued complaints of bilateral lower extremity radiculopathy. Patient did have temporary improvement of symptoms after ESI but has had recurrence. Patient's neurologic examination does not demonstrate weakness. Patient has attempted conservative treatments including therapy and interventional injections with ongoing symptoms. I have discussed the findings with the patient. The options of management including observation, further interventional pain management and therapy, or operative intervention with a left L4-5 and right L5-S1 laminotomy and discectomy was discussed. Pros and cons addressed. Due to failed conservative treatment and symptoms are affecting her day-to-day life patient wishes to proceed with operative intervention. Patient will follow up with me for presurgical consultation in the near future. Patient will continue to take spine and fall

precautions. Patient will contact the office with any concerns or changes in her condition in the interim. Patient demonstrates understanding and is in agreement with the treatment plans.

**Visit Codes**
99214 Office Visit, Est Pt., Level 4.

**Follow Up**
for presurgical consultation

**Electronically signed by Elias Dagnew , MD on 02/04/2021 at 01:29 PM EST**

**Sign off status: Completed**

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